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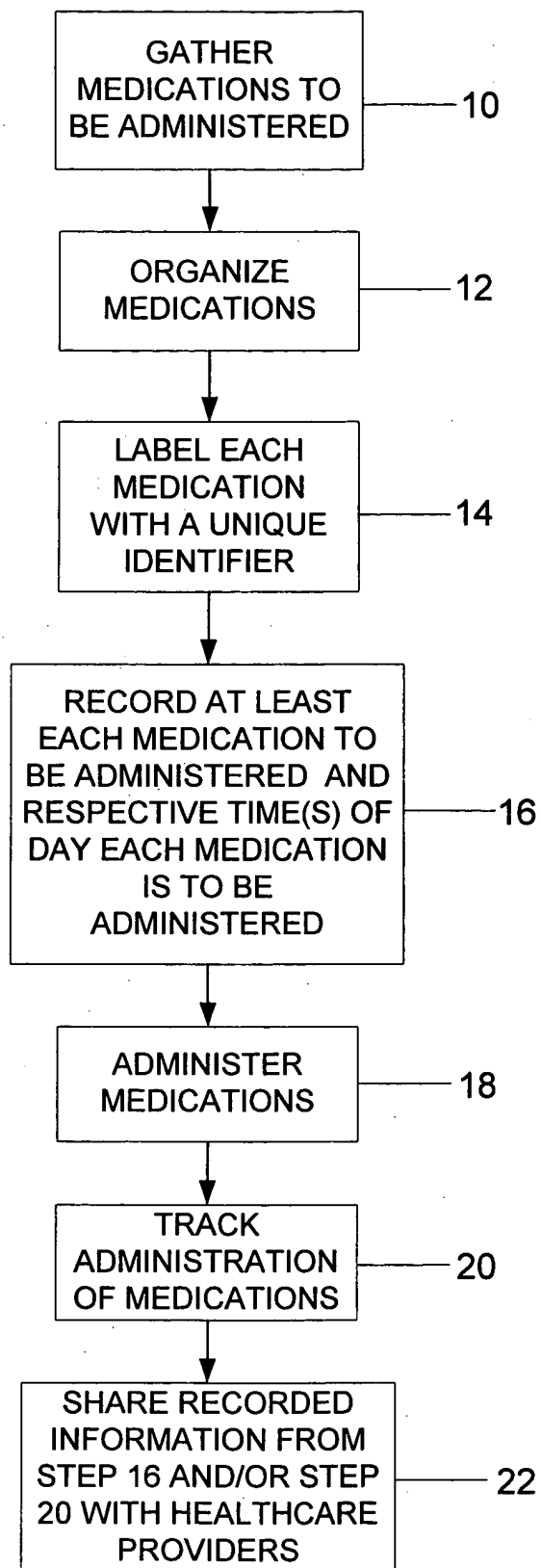


Fig. 1

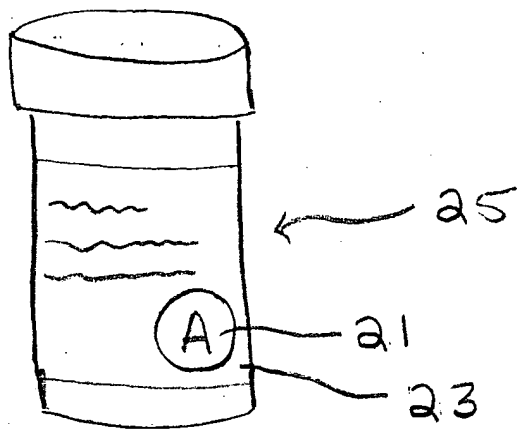


FIG. 2

Medication	Frequency				
	a.m.	noon	p.m.	bed	as needed
Medication 1	X		X		
Medication 2					X
Medication 3	X	X	X	X	
Medication 4		X			

30 → 32 34 36 38 40 42
 FIG. 3

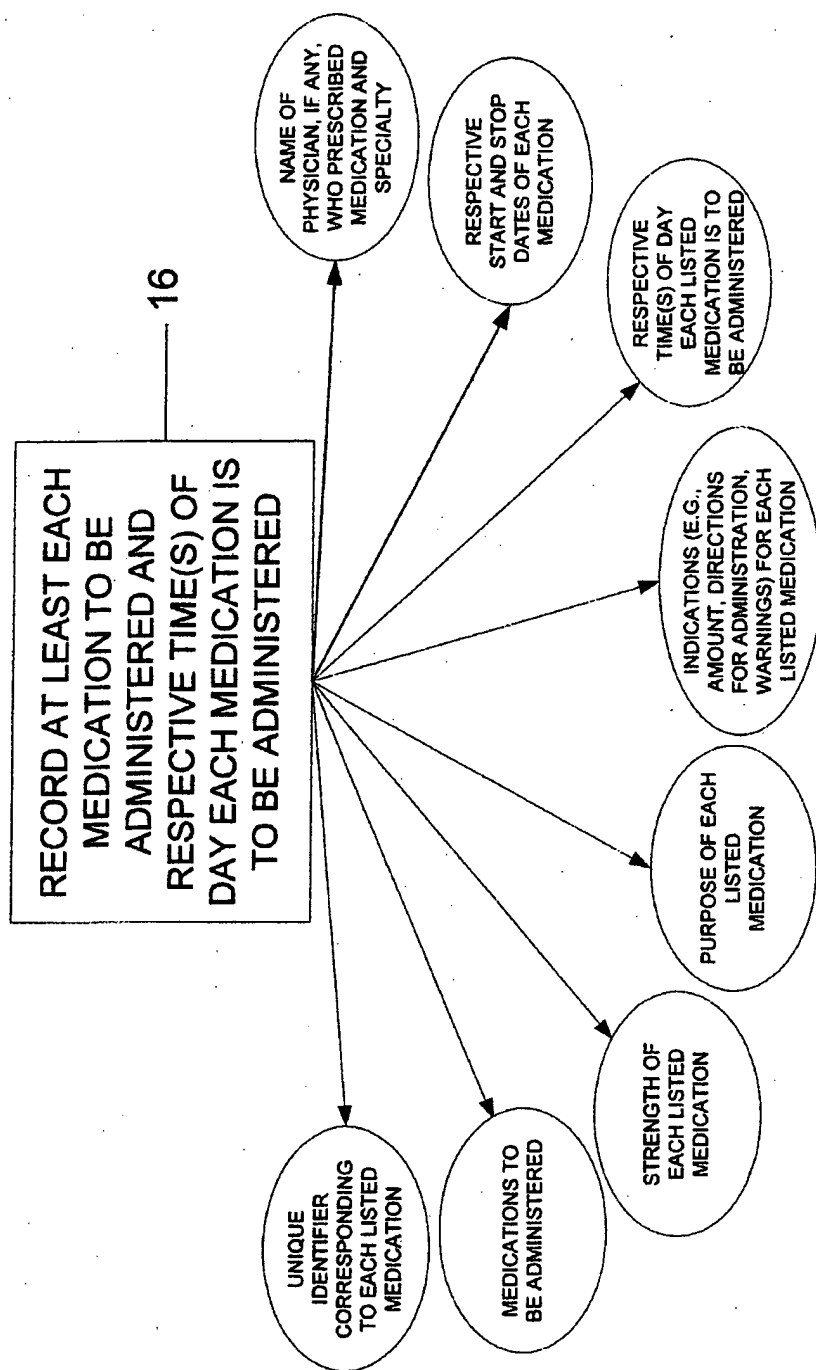


Fig. 4

[illegible][illegible]

↑ 51 ↑ 52 ↑ 53 ↑ 54 ↑ 55 — ↑ 56 ↑ 57 ↑ 58 ↑ 59 ↑ 60 ↑ 61 ↑ 62 ↑ 63

۱۵
 ۱۶
 ۱۷
 ۱۸

65

SEPT	week day:	am	noon	pm	as needed	notes:
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						

AUG	week day:	am	noon	pm	as needed	notes:
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						

JULY	week day:	am	noon	pm	as needed	notes:
1		✓	✓	✓	✓	
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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25						
26						
27						
28						
29						
30						
31						

↑ 66
 ↑ 67
 ↑ 68
 ↑ 69
 ↑ 70
 ↑ 71
 ↑ 72
 ↑ 73

FIG. 6

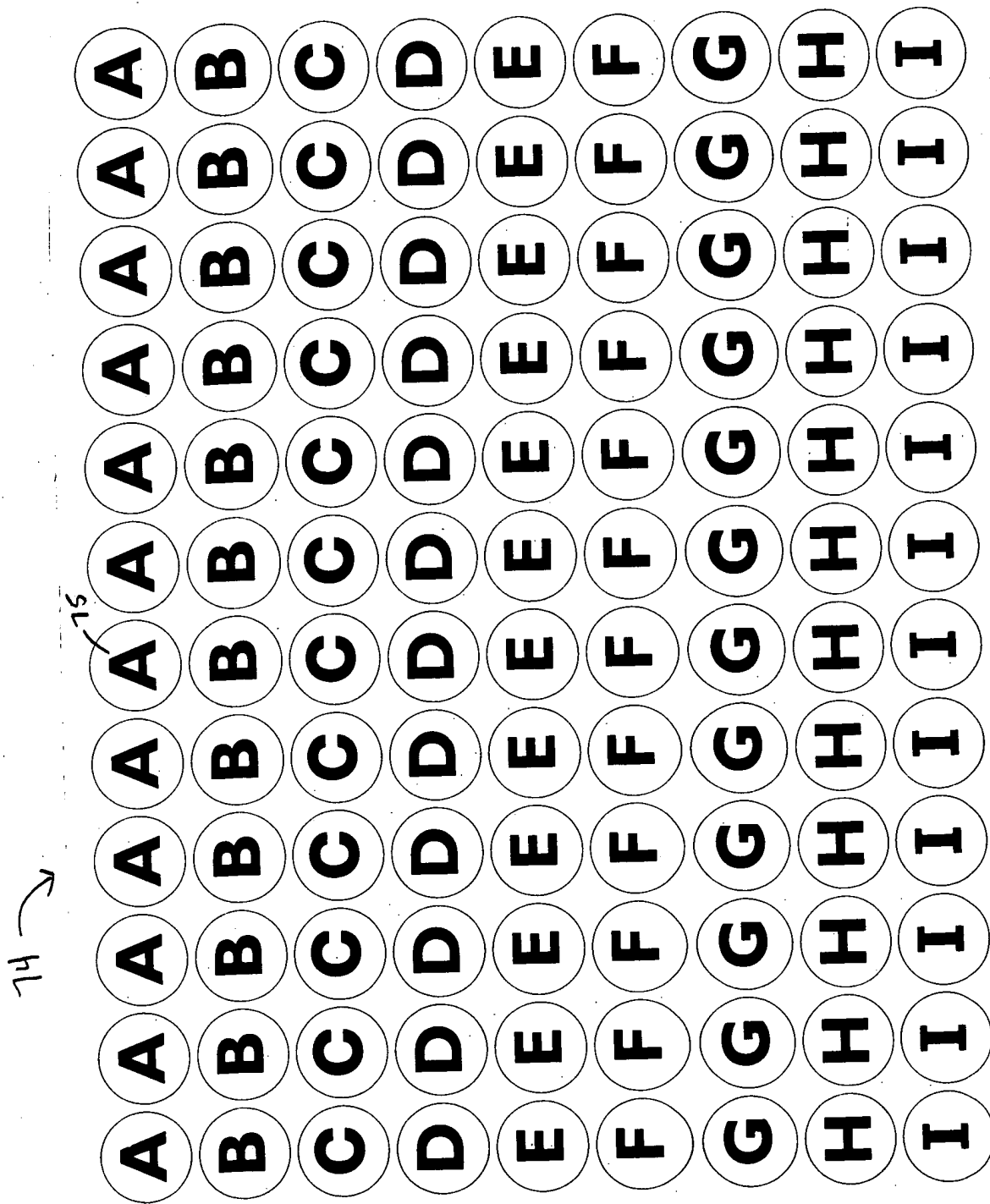


FIG. 7(a)

76 ↘ 77 ↓

name		date									
allergic to											
A-Z letter	medication / strength	purpose	amount / directions / warnings	Time of Day					start date	stop date	physician
				am	noon	pm	bed	as needed			

FIG. 7(b)

78 ↘ 79 ↓

JAN	week day:	am	noon	pm	bed	as needed	notes:
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

FEB	week day:	am	noon	pm	bed	as needed	notes:
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29 (day 28)							

MAR	week day:	am	noon	pm	bed	as needed	notes:
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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29							
30							
31							

FIG. 7(c)

INSTRUCTIONS



1. label...

- Gather all your prescription and over-the-counter medications. (Include herbal products, dietary supplements, pain relievers, eye drops, nose sprays, cough syrups, etc.)
- Under the red tab below, locate the **A-Z labels**. Place a different letter of the alphabet on each medication container.

If you refill a prescription, use the same letter of the alphabet on the new container.

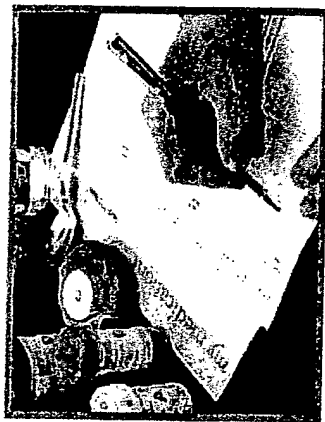


2. list...

Under the yellow tab below, locate a blank **medication chart**. A sample medication chart is visible when you lift the tab.

Using the **sample medication chart** as your guide, begin to list your medications. Start with medication **A**, then **B**, etc.

Review your medication chart with your physician or pharmacist on each visit.



3. take safely.

Every time you take your medications:

- Using your **medication chart** and your **A-Z labels** as guides, remove only those medications you need for that time of day.
- Read the directions and warnings on your chart before you take each medication.
- After you take each medication, place that container away from the others.
- Under the blue tab, locate the **daily checklist** for the current month. Indicate under the correct day and time that your medications were taken.

80 →

FIG. 7(d)

healthcare contacts

name

Dr.	specialty	Dr.	specialty	Dr.	specialty
phone		phone		phone	
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	
Dr.	specialty	Dr.	specialty	Dr.	specialty
phone		phone		phone	
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	
Dr.	specialty	Dr.	specialty	Pharmacy	
phone		phone		phone	
fax	e-mail	fax	e-mail	fax	
address		address		address	
Dr.	specialty	Dr.	specialty	Pharmacy	
phone		phone		phone	
fax	e-mail	fax	e-mail	fax	
address		address		address	

FIG. 7(e)

emergency contacts

name _____
date of birth _____

Emergency # 911	Hospital name	Insurance Co.
Fire Department #	phone	policy #
Police Department #	fax	I.D. #
Ambulance Service #	address	phone
National Poison Center 1-800-222-1222		address
Emergency contact	Clinic name	Insurance Co.
relationship	phone	policy #
phone (h) (w)	fax	I.D. #
cell phone	address	phone
e-mail		address
Emergency contact	ORGAN/DONOR TISSUE CARD:	MEDICAL CONDITIONS
relationship	witness phone	<input type="checkbox"/> asthma <input type="checkbox"/> infectious disease
phone (h) (w)	witness phone	<input type="checkbox"/> cancer <input type="checkbox"/> kidney disease
cell phone	date card was signed	<input type="checkbox"/> depression <input type="checkbox"/> liver disease
e-mail	location of card	<input type="checkbox"/> diabetes <input type="checkbox"/> emphysema
POWER OF ATTORNEY FOR HEALTHCARE:	LIVING WILL:	<input type="checkbox"/> heart disease <input type="checkbox"/> hypertension
name	attorney	ALLERGIES
phone	phone	medications: _____
date of document	date of will	food: _____
location of document	location of will	other: _____

FIG. 7(f)

PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATIONS

name _____ relationship _____ cell ①
home ① _____ work ①
city _____ state _____ zip _____

insurance co. _____
policy holder _____
member ID# _____
group ID# _____
phone _____ fax _____

Medicare ☐ yes ☐ no

Medicare ☐ yes ☐ no

name _____
address _____
phone _____ fax _____

name _____ specialty _____
address _____
phone _____ fax _____

name _____ specialty _____
address _____
phone _____ fax _____

90-1

PREScriptions AND

OVER-THE-COUNTER MEDICATIONS

[illegible]

MEDICAL CONDITIONS

<input type="checkbox"/> asthma	_____
<input type="checkbox"/> cancer	_____
<input type="checkbox"/> depression	_____
<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> emphysema	_____
<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> hypertension	_____
<input type="checkbox"/> infectious disease	_____
<input type="checkbox"/> kidney disease	_____
<input type="checkbox"/> liver disease	_____

ALLERGIES

medications: _____
 food: _____
 other: _____

Vital Information WALLET CARD

PERSONAL INFORMATION

name _____
address _____
city _____ state _____ zip _____
home ☎ _____ work ☎ _____
birthdate ____ / ____ / ____ SS # ____ - ____ - ____
☐ male ☐ female blood type _____
blood pressure ☐ normal ☐ high ☐ low
organ/tissue donor ☐ yes ☐ no
donor card location _____
living will ☐ yes ☐ no
living will location _____

1901

Do you need help
organizing your medications?
Ask your Kerr Drug pharmacist about
my med manager

KERR DRUG

1-800-000-0000

www.kerrdrug.com

Vital Information Wallet Card
brought to you by

GLAXOSMITH-KLINE

FIG. 7(q)

92 ✓ 93

name John Doe
allergic to penicillin
date 1/16/04

A-Z letter	medication / strength	purpose	amount / directions / warnings	Time of Day					start date	stop date	physician
				am	noon	pm	bed	as needed			
A	hydralazine HCl 25 mg	high blood pressure	1 tablet twice a day	X		X			4/8/02		Kline (cardiologist)
B	warfarin 5 mg	blood thinner	1 tablet once a day (limit vitamin K foods, such as kale, spinach, broccoli)	X					5/20/02		Kline (cardiologist)
C	timolol 0.25%	glaucoma	1 drop in each eye twice a day	X		X			12/10/03		Carter (ophthalmologist)
D	hydrocodone GF	cough	1 teaspoonful (5 mL) every four hours for five days	X	X	X	X	X	1/16/04	1/20/04	Anderson (internist)
E	promethazine HCl 25 mg	nausea and vomiting	1 in rectum every six hours as needed (keep in refrigerator)					X	2/1/04		Anderson (internist)
F	calcium 600 mg	bone strength	1 tablet three times a day	X	X	X			2/14/04		
G	St. John's wort	mood	1 capsule three times a day	X		X	X		3/18/04		
H	albuterol	shortness of breath	2 inhalations every four to six hours as needed (avoid caffeine)					X	4/24/04		Robinson (allergist)
I	zolpidem 10 mg	insomnia	1 tablet at bedtime for sleep as needed (no alcohol)					X	5/20/04		Martin (psychiatrist)
J	ciprofloxacin 500 mg	infection	1 tablet twice a day (on an empty stomach)	X				X	5/25/04	5/31/04	Smith (urologist)

FIG. 7(h)

95 ← 94 ↙

JAN	physician	purpose of visit	FEB	physician	purpose of visit
MAR	physician	purpose of visit	APR	physician	purpose of visit
MAY	physician	purpose of visit	JUNE	physician	purpose of visit

Use this calendar section to keep track of routine checkups with your internist, dentist, dermatologist, ophthalmologist, etc. Next year use it as a reminder to schedule these routine appointments in advance. Ask your physician(s) to recommend the appropriate exams, tests, and vaccinations for your age and condition. Below is a suggested screening checklist.

FEMALE/MALE	FEMALE
skin	breast
eye/vision	mammogram
hearing	pelvic/cervical
dental	pap smear
height/weight	bone density
blood pressure	
cholesterol	
blood chemistry	
urinalysis	
colorectal	
colonoscopy (if > 50)	
electrocardiogram	
chest X-ray	MALE
complete physical	testicular
	digital rectal
	prostate exam

VACCINATIONS

influenza	
pneumococcal	
tetanus	

JULY	physician	purpose of visit	AUG	physician	purpose of visit
SEPT	physician	purpose of visit	OCT	physician	purpose of visit
NOV	physician	purpose of visit	DEC	physician	purpose of visit

Physician's recommended screenings for next year

Notes

FIG. 7(i)

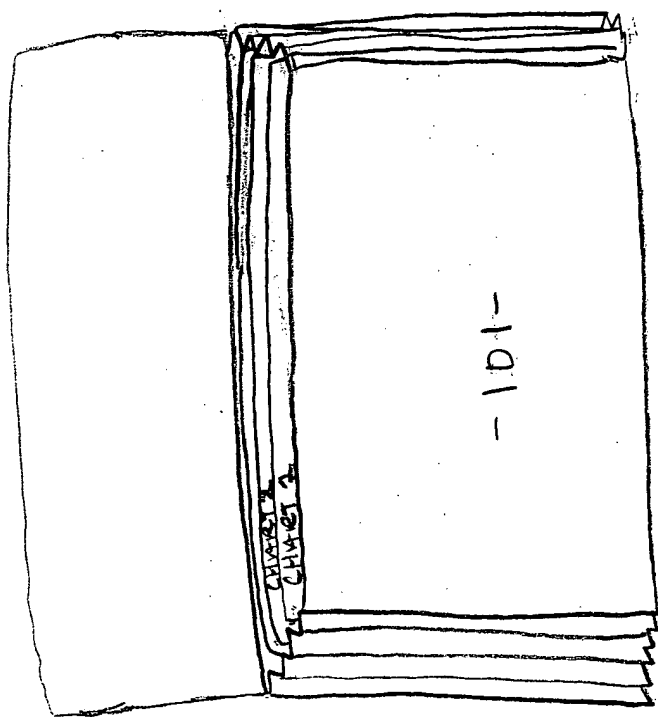
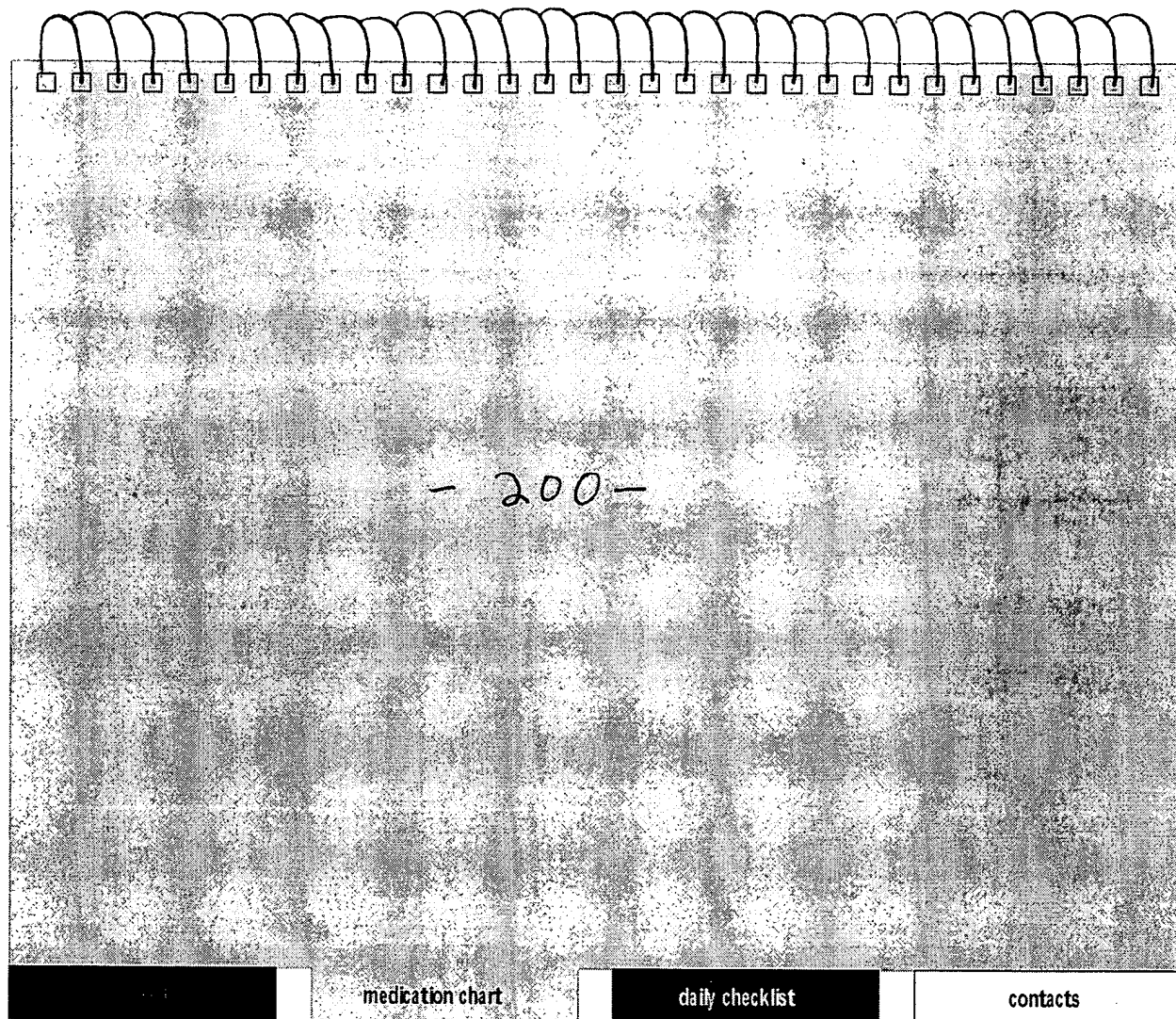


FIG. 7(j)



201

FIG. 7(k)